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IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Seventh Circuit

BRIEF OF AMERICAN ASSOCIATION OF HEALTH PLANS, INC., AMERICAN BENEFITS COUNCIL, AND HEALTH INSURANCE ASSOCIATION OF AMERICA, INC., AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether the external review provision of the Illinois Health Maintenance Organization Act, 215 ILL. COMP. STAT. 125/4-10, is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq*.

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BRIEF OF AMERICAN ASSOCIATION OF HEALTH PLANS, INC., AMERICAN BENEFITS COUNCIL, AND HEALTH INSURANCE ASSOCIATION OF AMERICA, INC., AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

INTEREST OF *AMICI CURIAE*[1]

The question presented in this case is whether Illinois' independent review statute—which requires health maintenance organizations to submit disputed "medical necessity" coverage determinations to the binding judgment of a non-plan physician—is preempted by ERISA. *Amici* have a vital interest in the correct resolution of this case, because each (through its members) has a significant stake in preserving uniformity in the federal law governing employee welfare benefits plans, and each (through its members) will be adversely affected by a decision upholding a State's authority to enact state-law remedies that constitute alternatives to ERISA's exclusive civil enforcement scheme.

The American Association of Health Plans, Inc. ("AAHP") is the national association for the managed health care community. Its membership includes health maintenance organizations, preferred provider organizations, third party health benefit administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1000 managed health care organizations serving nearly 150 million Americans. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy, and the provision of services to member health plans.

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[1] Pursuant to this Court's Rule 37.3(a), letters of consent from all parties to the filing of this brief have been filed with the Clerk. Pursuant to this Court's Rule 37.6, *amici* state that this brief was not authored in whole or in part by counsel for any party, and that no person or entity other than *amici*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

The American Benefits Council ("Council") is one of the nation's leading advocates of employer-sponsored benefits programs. Its members sponsor, administer, or provide services to health, retirement, and stock compensation plans covering more than 100 million Americans. The Council is dedicated to promoting sensible regulation of employer-sponsored benefits programs and to eliminating regulatory proposals that impose unnecessary burdens, liabilities and costs on employers that elect to sponsor benefit plans.

The Health Insurance Association of America ("HIAA") is based in Washington, D.C., and is one of the largest associations of health insurance companies in the world. HIAA comprises more than 290 members which provide insurance for medical expenses, long-term care, and disability to more than 123 million Americans. HIAA advocates a private, market-based health insurance system and is dedicated to promoting federal and state health care policies that maximize the quality, affordability, accessibility, and responsiveness of medical services provided to the nation's health care consumers.

STATEMENT

1. Petitioner Rush Prudential HMO, Inc. ("Rush") is a health maintenance organization ("HMO") that contracts with employers and others to provide services to employee welfare benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. In this particular case, Rush contracted with an employer to provide coverage for medical and hospital care to subscribing employees on a prepaid basis. Under the terms of the controlling ERISA plan document, Rush was obliged to provide coverage only for services that it determined to be "medically necessary," as that term was defined by the ERISA plan, and was afforded "the broadest possible discretion" to make those determinations. *Moran*, 230 F.3d at 962.

Respondent Deborah C. Moran was covered as a spouse under the ERISA plan to which Rush provided services. *Moran*, 230 F.3d at 962. In 1996, Moran sought treatment

for "pain, numbness, loss of function, and decreased mobility in her right shoulder" from Dr. Arthur LaMarre, a Rush-affiliated primary care physician, who treated Moran with physiotherapy and other conservative approaches. *Id.* When those efforts did not relieve her symptoms, Moran requested an out-of-network referral to be examined by Dr. Julia Terzis, a thoracic surgeon in Virginia who specializes in neuromuscular disorders. After Rush denied that request, Moran traveled to Virginia on her own accord to see Dr. Terzis, who diagnosed Moran with a nerve compression abnormality called thoracic outlet syndrome ("TOS"). Dr. Terzis recommended that Moran undergo a form of microneurolysis surgery that, all parties have conceded, is more complicated than the operation ordinarily performed on patients afflicted by TOS. *See id.* at 963-65.

Upon her return, Moran requested Rush to precertify the surgery Dr. Terzis had proposed. Although Dr. LaMarre concluded that the proposed surgery was "medically necessary," Rush denied coverage on the ground that it would be provided by an out-of-network physician. On Moran's appeal of that decision, and pursuant to its internal grievance procedure, two Rush-affiliated thoracic surgeons examined Moran and concluded that the procedure Dr. Terzis had proposed was not medically necessary because Moran required *standard* TOS surgery. After reviewing those surgeons' reports and conducting its own analysis of the relevant medical literature, Rush affirmed the coverage denial. *See id.* at 964.

2. Section 4-10 of the Illinois Health Maintenance Organization Act (the "Act"), 215 ILL. COMP. STAT. 125/4-10, provides that in the event of a dispute between a primary care physician and an HMO "regarding the medical necessity of a covered service proposed by [the] primary care physician," the HMO must "provide a mechanism for the timely review" of the dispute by an independent physician. Enacted in response to citizen complaints about the cost-containment practices of managed care companies, the Act provides that in the event the reviewing physician determines the covered service

to be "medically necessary," the HMO "*shall* provide the covered service." *Id.* (emphasis added).[2]

Following the final administrative denial of her coverage request, Moran served Rush with a written demand to appoint an independent physician pursuant to Section 4-10. *See Moran*, 230 F.3d at 965. Before Rush responded to the demand, Moran elected to undergo the surgery Dr. Terzis had proposed—a procedure that, including post-operative care, cost $98,841.27. Moran submitted the bill for the operation to Rush, which treated her submission as a renewed request for benefits and asked three medical experts, including the

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[2] Section 4-10 was enacted in Public Act 85-20 (eff. July 20, 1987). In the floor debate in the House of Representatives, Representative Shaw, a principal sponsor of the bill, explained that it "addresses several concerns which has [sic] been expressed concerning the operation of health maintenance organizations over the last year in Illinois." Transcription Debate, 85th General Assembly, 67th Legislative Day (June 24, 1987) at 233. "[T]he patient complaint and grievance procedure. And I think, from what I've heard around the state, the many patients, when they was [sic] involved in an HMO, they had nowhere to go and this was one of the things that they protested vigorously about, and I think it's this type of procedure that needs to be set forth." *Id.*; *see also id.* at 233-34 ("if they can't agree on the second opinion, then a third opinion is provided, and that opinion is binding * * * * [I]t doesn't solve all the problems that's dealing with HMO [sic], but I think that this is a milestone in legislation that the people of Illinois can live with and I ask for its adoption").

Illinois recently enacted an even more comprehensive "external review" provision as part of the Managed Care Reform and Patient Rights Act, P.A. 91-617 (eff. Jan. 1, 2000), codified at 215 IL. COMP. STAT. 134/1 *et seq*. The statute applies to HMOs (*see* 215 IL. COMP. STAT. 125/5-3.6), and thus imposes additional procedural requirements on them. Unlike Section 4-10, the Patient Rights Act does not limit external review to circumstances in which a primary physician and HMO disagree over whether treatment is "medically necessary." It applies to virtually all "medical necessity" determinations, as well as to coverage decisions about hospital stays and referrals to specialists. *See* 215 IL. COMP. STAT. 134/45(e). The Patient Rights Act also establishes precise timetables for completion of the independent review and expressly requires the plan to pay the fees of the external reviewer. *See* 215 IL. COMP. STAT. 134/50(f).

Chief of Plastic and Reconstructive Surgery at Washington University School of Medicine in St. Louis, to review her medical file. When none of those experts concluded that the surgery performed by Dr. Terzis was medically necessary, Rush again denied Moran's claim. *Moran*, 230 F.3d at 965.

Undeterred by the second denial of her claim for benefits, Moran filed a complaint against Rush in the Circuit Court of Cook County seeking "specific performance" of the independent review provision in Section 4-10. Over Rush's objection, the Circuit Court ordered Rush to submit Moran's claim to an independent reviewer, and Rush and Moran agreed to have the independent review conducted by Dr. A. Lee Dellon of Johns Hopkins Medical Center. Like the Rush-affiliated thoracic surgeons who had examined Moran, Dr. Dellon concluded that he would have performed a much less intrusive and time consuming procedure, but he nonetheless opined that the surgery performed by Dr. Terzis had been "medically necessary." *Moran*, 230 F.3d at 965.

3. Citing Dr. Dellon's findings, Moran amended her state court complaint to seek "reimbursement" from Rush for the costs of her operation. Because Moran's amended claim was in effect a claim for plan benefits—a claim that already had been twice denied pursuant to Rush's internal plan procedures—Rush then removed the complaint to federal court. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987) (holding that the exclusivity of the remedies provided by ERISA § 502(a), 29 U.S.C. § 1132(a), permits removal). Moran moved to remand the action to state court on the ground that her suit was predicated on a state law that regulated insurance within the meaning of ERISA's "saving clause," 29 U.S.C. § 1144(b)(2)(A).

The district court first addressed Moran's motion to remand and concluded that her Section 4-10 cause of action was preempted by ERISA § 502(a). Pet. App. 41a. "Regardless of how she characterizes it," the district court explained, "Moran's current claim is a § 502(a) denial of benefits claim" because it contests "Rush['s] refusal to reimburse her for the

treatment" rendered by Dr. Terzis. *Id.* The district court rejected Moran's claim that Section 4-10 was saved from preemption by ERISA's insurance saving clause, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), reasoning that Section 4-10 does not regulate insurance because it does not spread or transfer risk or "affect the disbursement of benefits * * * to all [Rush subscribers] * * * or mandate or deny a certain class of benefits." Pet. App. 42a (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985)). Finding no abuse of discretion in the denial of Moran's claim, the district court entered summary judgment for Rush.

4. The Seventh Circuit reversed. Although agreeing that removal had been proper because "Moran's state law claims are properly recharacterized as claims for benefits under § 502(a)(1)(B) of ERISA" (*Moran*, 230 F.3d at 967), the court of appeals concluded that Rush had abused its discretion in denying Moran's claim for reimbursement. As the court of appeals saw the issue, Rush was obliged to comply with the "independent review of Dr. Dellon" (*id.* at 965), because Section 4-10 had become part of Moran's contract with Rush "by operation of [Illinois] law." *Id.* at 969 ("[Statutory] provisions * * * are substantive terms of all insurance policies in Illinois by operation of law").

The court of appeals rejected Rush's contention that Section 4-10 was preempted by ERISA. In particular, the court of appeals rejected Rush's claim that Section 4-10 is an alternative enforcement mechanism to Section 502(a) that is preempted by the teaching of *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Notwithstanding its recognition that Section 4-10 "establishes an additional * * * mechanism for making decisions about medical necessity" that adds "an additional dispute resolving mechanism" to the plan (*Moran*, 230 F.3d at 972), the court of appeals concluded that because Section 4-10 had been "incorporated into * * * Moran's insurance contract" by operation of Illinois law, it could "not be characterized as creating an alternative remedy scheme that conflicts with § 502(a)." *Id.* Rather, Moran's suit was "simply a suit to enforce the terms of the plan." *Id.* (citing *UNUM Life*

Ins. Co. v. Ward, 526 U.S. 358, 377 (1999) ("*Ward*")). The court of appeals went on to explain that although Section 4-10 nonetheless "relate[d] to" an ERISA plan within the meaning of Section 514(a), 29 U.S.C. § 1144(a)—a point that Moran had in any event conceded (*see Moran*, 230 F.3d at 968)—it was saved from preemption as a law that regulates insurance under 29 U.S.C. § 1144(b)(2)(A). *Id.* at 969.

The court of appeals expressly noted that its decision conflicted with the Fifth Circuit's decision in *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000) (holding that Texas' external review statute was preempted by ERISA because it established an "alternative enforcement mechanism" to Section 502), *on reh'g*, 220 F.3d 641 (same), *petition for cert. filed sub nom., Montemayor v. Corporate Health Ins., Inc.*, No. 00-665 (Oct. 24, 2000) ("*Montemayor*"). The court of appeals concluded, however, that the Fifth Circuit had erred in holding that a state independent review law "creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan," *Montemayor*, 215 F.3d at 539. According to the court of appeals, such statutes "simply add[] to the contract, by operation of law," and therefore a suit to enforce them is nothing more than a suit "to enforce the terms of the plan." *Id.* at 970; *see also Moran*, 230 F.3d at 971 (the "'sole launching ground' for Ms. Moran's claims to enforce § 4-10 * * * remains § 502(a)") (quoting *Ward*, 526 U.S. at 377).

5. Judge Posner, joined by Judges Coffey, Easterbrook, and Diane P. Wood, dissented from the denial of rehearing *en banc*. Judge Posner characterized the panel's decision as "startling" and noted that Section 4-10 is plainly preempted by ERISA because it "establishes a system of appellate review of benefits decisions that is distinct from" Section 502(a) and thus "interferes with the federally specified system for enforcing" plan benefits. 230 F.3d at 973-74. Judge Posner also dismissed as a "*façon de parler*" the panel's view that Section 4-10 somehow was incorporated into the terms of Moran's plan by operation of law. *Id.* at 973. Not only

does that approach "invite[] states to evade [ERISA's] preemptive force * * * simply by deeming its regulations of ERISA plans to be plan terms," he observed, but it suffers from a logical inconsistency: if the plan "merely regulates insurance and therefore is not preempted," it cannot "be part of an ERISA plan and enforceable in federal court." *Id.* at 973-74.

Judge Posner also explained that the panel's reliance on *Ward* was misplaced because *Ward* saved from preemption a state law that "was a typical regulation of insurance rather than anything either special to ERISA plans or likely to be mischievous in its impact on those plans." 230 F.3d at 973. Indeed, "[f]ar from being compelled by [*Ward*], the panel's opinion is in tension with *Pegram v. Herdrich*, 530 U.S. 211 (2000)," a decision which—unlike the panel's—"did not doubt that ERISA applied to HMO-managed ERISA plans." *Id.* Judge Posner cautioned that the panel's decision would "add[] heavy new procedural burdens to ERISA plans" and "undermine[] the * * * federal uniformity in the administration" of employee benefit plans that ERISA was enacted to ensure. *Id.*

SUMMARY OF ARGUMENT

The judgment of the court of appeals cannot be reconciled with the consistent course of this Court's ERISA cases, all of which make clear that the civil enforcement provisions in ERISA § 502(a) are exclusive and preempt state laws that purport to authorize alternative avenues of relief. Because Section 4-10 unquestionably establishes an "alternative enforcement mechanism" (*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995)) to the remedies provided in section 502(a), it is preempted by ERISA §§ 502(a) and 514(a).

The court of appeals erred in concluding that Section 4-10 is saved from preemption as a law regulating insurance. In *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), this Court unanimously held that state laws that establish alternative enforcement mechanisms to section 502(a) do *not* constitute

laws that "regulate insurance" within the meaning of ERISA's saving clause. *Pilot Life* not only stands for the proposition that Section 502 remedies preempt conflicting state laws under conventional conflict preemption principles. It made clear that the exclusivity of Section 502 remedies is so important to ERISA's design that it must inform judicial interpretation of the scope of the business of "insurance" that Congress intended to reserve for the States. Because "the role of the saving clause in ERISA as a whole" demonstrates that it was not intended to save state laws that purport to "supplement[] or supplant[]" the exclusive remedies that Congress made available in Section 502(a) (*Pilot Life*, 481 U.S. at 56), the alternative remedy provided by Section 4-10 cannot be saved under that provision.

In any event, Section 4-10 does not constitute a law that regulates insurance from "a common sense view of the matter" (*UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 367 (1999)), or as measured by the three McCarran-Ferguson Act guideposts. Section 4-10 is not directed at insurance or the insurance industry, but at HMOs. The law does not spread or transfer risk, it is not integral to the policy relationship between an insurer and insured, and it does not affect only entities in the insurance industry. Whatever else it may be, Section 4-10 is not a law that regulates insurance within the meaning of ERISA's saving clause. The judgment of the court of appeals must be reversed.

ARGUMENT

ILLINOIS' STATUTE IS CLEARLY PREEMPTED BY ERISA BECAUSE IT CONFLICTS WITH SECTION 502(A) AND IS NOT SAVED FROM PREEMPTION BY THE INSURANCE SAVING CLAUSE.

Illinois' independent review requirements purport to establish a binding enforcement mechanism for claimants who are dissatisfied with the health benefits provided by their HMOs. Those requirements constitute precisely the sort of alternative state law remedy that Congress intended to preempt with Section 502(a)'s comprehensive remedial scheme.

A. Illinois' Statute Constitutes An Alternative Enforcement Mechanism Preempted By Sections 502(a) And 514(a).

1. Section 514(a) of ERISA preempts State laws "insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Although this Court has cautioned that "the term 'relate to' cannot be taken 'to extend to the furthest stretch of indeterminacy,' or else 'for all practical purposes pre-emption would never run its course,'" *Egelhoff v. Egelhoff*, 121 S. Ct. 1322, 1327 (2001) (quoting *Travelers*, 514 U.S. at 655), this Court's cases make clear that state laws unquestionably are preempted to the extent they purport to authorize "alternative enforcement mechanisms" (*Travelers*, 514 U.S. at 658) to the exclusive remedial provisions set forth in Section 502 of ERISA, 29 U.S.C. § 1132.

That principle was established in this Court's unanimous decision in *Pilot Life*, which held that state-law contract and tort claims filed against an insurer for the "bad faith" denial of certain disability benefits under an ERISA plan were preempted by section 514(a). *Pilot Life*, 481 U.S. at 55-56. Although the tort of "bad faith" had long been used to seek damages for wrongful benefits denials, the Court concluded that permitting such a cause of action would amount to giving plan beneficiaries an alternative enforcement mechanism for contesting the denial of ERISA benefits. *Id.* at 54, 57. As the Court explained, any state-law cause of action that amounts to such an alternative enforcement action is preempted by ERISA, because Congress clearly intended for the remedies set forth in ERISA § 502(a), 29 U.S.C. § 1132(a), to be exclusive:

> The six carefully integrated civil enforcement provisions found in § 502(a) of the statute * * * provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.

Id. at 54 (emphasis in original). The Court explained that Congress' decision to make the remedial provisions of Section 502(a) exclusive "would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain [alternative] remedies under state law[.]" *Id.*

On the same day it decided *Pilot Life*, this Court held that the preemptive effect of ERISA's civil enforcement provisions is so strong and complete that an ERISA preemption defense under section 502(a) provides a sufficient basis to remove a state cause of action to a federal forum, notwithstanding the traditional limitation imposed by the well-pleaded complaint rule. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987). Like *Pilot Life*, *Taylor* made clear that respect for the exclusivity of ERISA's civil enforcement scheme is essential "to ensure that plans and plan sponsors [are] subject to a uniform body of benefits law," *Travelers*, 514 U.S. at 656, and that state laws that interfere with that enforcement scheme—and *especially* state laws that provide *alternatives* to it—are preempted by *both* sections 514(a) and 502(a). *Taylor*, 481 U.S. at 64.

The Court reiterated and extended those principles in *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990). There, the Court held that ERISA preempted a state wrongful discharge cause of action predicated on an employee's allegation that he had been terminated to prevent his plan benefits from vesting. Relying on *Pilot Life* and *Taylor*, the Court concluded that McClendon's claim was preempted by Section 514(a) and ordinary "requirements of conflict preemption," because McClendon's state-law claim purported "to provide a remedy for the violation of a right expressly guaranteed by [ERISA] and exclusively enforced by Section 502(a)." *Id.* at 144. The Court explained that "'when it is clear or may fairly be assumed that the activities which a State purports to regulate are protected by * * * [ERISA], due regard for the federal enactment requires that state jurisdiction must yield.'" *Id.* (quoting *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 409 n.8 (1988)).

2. There can be no dispute that under those precedents Section 4-10 constitutes an impermissible alternative state-law remedy to recover plan benefits that goes beyond the exclusive remedies set forth in Section 502(a). As Judge Posner recognized in his dissent from the denial of rehearing *en banc* below, Illinois' "law establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans." 230 F.3d at 973. The Fifth Circuit in *Montemayor* also had little trouble concluding that Texas' external review statute "establish[es] a quasi-administrative procedure for the review of [benefits] denial[s]" and thus "creates an alternative mechanism through which plan members may seek benefits due them." *Montemayor*, 215 F.3d at 539.

The Seventh Circuit attempted to evade that conclusion by treating Section 4-10 as a permissible "mandated contract term" that became part of the ERISA plan—and thus enforceable in an action under Section 502(a)—by operation of state contract law. *Moran*, 230 F.3d at 969 ("[Illinois'] statutory provisions enter into and form a part of all contracts of insurance" in the State). In support of that characterization of the state statute, the court of appeals cited *Ward*, which held that California's notice-prejudice rule was saved from preemption as a law regulating insurance, and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), which held that a state law mandating mental health benefits was not within ERISA's preemptive reach. *See* 230 F.3d at 969-70.

Neither *Ward* nor *Metropolitan Life* supports the proposition that States may evade preemption under ERISA simply by adopting a rule that purportedly incorporates state statutes into any benefits plan "by operation of law." *Metropolitan Life* involved a mandated benefit—a substantive coverage requirement—not any remedy beyond those enumerated in ERISA § 502, and the Court did not advert to any Massachusetts doctrine that incorporates state statutes into insurance contracts "by operation of law" or otherwise. *See* 471 U.S. at

741. Although *Ward* did state that the notice-prejudice rule "*effectively* create[d] a mandatory contract term" (*Ward*, 526 U.S. at 374) (emphasis added), it did not base that conclusion on the existence of any California doctrine requiring the incorporation of state insurance laws into insurance contracts. Read in context, that statement merely reflected the Court's conclusion that because the state law was saved from preemption, it was "effectively" binding on the plan. *Id.* at 375-76.

At most, *Ward* and *Metropolitan Life* stand for the proposition that a state-law requirement may "effectively" (*Ward*, 526 U.S. at 374) be considered a term of an ERISA plan if it does not otherwise conflict with ERISA's substantive provisions or stand as an obstacle to the accomplishment of ERISA's objectives. Neither decision, however, purports to establish a principle that would permit States to enact alternative enforcement mechanisms to Section 502(a) simply by deeming those mechanisms to be provisions of the plan. Indeed, the panel's logic would permit the "transparent * * * evasion of ERISA's preemption clause," *Moran*, 230 F.3d at 972-74 (Posner, J., dissenting from denial of reh'g *en banc*), because States could evade Section 514(a)'s preemptive reach entirely through the simple artifice of declaring their laws "incorporated" into plan documents. By that logic, a state law that required all coverage determinations to be reviewed by a state "board of HMO review," or a state law that purported to require HMOs to pay subscribers compensatory and punitive damages in the event an "independent reviewer" determined the plan had denied coverage in "bad faith," would be saved from preemption, because a suit to enforce those requirements would not be an impermissible "alternative enforcement mechanism" (*Travelers*, 514 U.S. at 658), but rather a suit "to enforce rights and to recover benefits *under the plan*." *Moran*, 230 F.3d at 971 (emphasis added). *Ward*'s description of the notice-prejudice rule as a "mandated contract term" simply cannot be stretched so far as to stand for a rule of law that would completely eviscerate ERISA preemption whenever States deem preemption incon-

venient. *See Citizens Bank of Maryland v. Strumpf*, 516 U.S. 16, 20 (1995) ("It is an elementary rule of construction that the act cannot be held to destroy itself.")[3]

Moreover, the Seventh Circuit's "mandated contract term" analysis is inconsistent with *Ingersoll-Rand*, which makes clear that a state law must be viewed as an impermissible alternative enforcement mechanism whenever it "purports to provide a remedy for the violation of a right expressly guaranteed by [ERISA's substantive provisions]" (*Ingersoll-Rand*, 498 U.S. at 145), and with *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), which holds that federal courts must give deferential review to benefits determinations whenever plan documents give administrators discretionary authority over those determinations, *id.* at 110-15. Respondent's cause of action under Section 4-10 seeks recovery of no more (and no less) than the benefit to which she is entitled under her plan: coverage for "medically necessary" care. Section 4-10, however, essentially eliminates "the broadest possible discretion" that plan documents expressly confer on Rush, and thus the statute compels federal courts simply to enforce, without further inquiry, the judgment of the state-law "reviewer." There can be no doubt that Section 4-10 is not a "mandated contract term," but an alternative "launching ground for an ERISA enforcement action." *Ward*, 526 U.S. at 377.[4]

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[3] Under the panel's analysis, whether state external review statutes constitute "alternative enforcement mechanisms" will apparently depend entirely on the vagaries of state contract law. For example, under Texas law, which was at issue in *Montemayor*, not every law is incorporated into every contract of insurance. *See Jun v. Lloyds*, No. 37 S.W.3d 59 (Tex. App.—Austin, 2000, pet. denied).

[4] The Secretary of Labor recently promulgated regulations pursuant to Section 503. *See* 65 Fed. Reg. 70246 (November 21, 2000) (eff. January 20, 2001) (applicable to claims filed on or after July 1, 2002 but not later than January 1, 2003 (*see* Claims Procedure; Notice of Extension of Applicability Date, 66 Fed. Reg. 35885 (July 9, 2001)). Although the new claims processing procedures prescribed by the new regulations do not purport to preempt State "external review" laws, those regulations nonetheless make clear that the Secretary does not share the Seventh Circuit's view that external review laws are simply mandated plan terms. *See* 29 C.F.R. §§ 2950(k)(i)-(ii). That is because the regulations provide that a beneficiary need not exhaust remedies under those State laws before initiating a suit for benefits under Section 502. *See id.* Given the well-settled rule requiring plan beneficiaries to exhaust their plan remedies before initiating suit under Section 502 (*see Ravencraft v. UNUM Life Ins. Co. of Am.*, 212 F.3d 341, 343 (6th Cir. 2000), the Secretary of Labor obviously believes that State external review requirements cannot reasonably be viewed as an additional plan remedy, but rather amount to alternative enforcement mechanisms. *See* 65 Fed. Reg. at 70254 ("[I]n the Department's view, th[ose] [State laws] are not part of the claims procedures contemplated by Section 503 of the Act, but are 'external reviews' that are beyond the scope of the regulation.").

3. Illinois' external review statute not only creates an alternative enforcement mechanism forbidden by *Pilot Life* and its progeny, but also would, if permitted to survive ERISA preemption, frustrate Congress' aim of "avoid[ing] a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. As this Court explained in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987):

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants * * * [and] making disbursements * * * The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to * * * process claims in a certain way in some States but not in others * * *

Id. at 9.

[Footnote continued from previous page]

Validation of Illinois' external review law or similar laws enacted by other States would clearly frustrate Congress' goal of "secur[ing] national uniformity in the administration of employee benefit plans," *Boggs v. Boggs*, 520 U.S. 833, 842 (1997), because plan administrators would be required to make benefits determinations—a central concern of ERISA—under statutory regimes that not only vary from one state to the next, but also potentially subject administrators to overlapping or inconsistent external review requirements. Indeed, several states—California, Maryland, and Virginia, for example—apparently would apply their external review procedures to any contract concluded in their state, even if that contract governs the availability of benefits to subscribers that may reside (and receive medical treatment) elsewhere, and even if the state where the subscriber resides has adopted some other approach to external review.[5] A result more antithetical to Congress' policy could scarcely be imagined.

[5] *Compare* MD. CODE ANN. § 15-10A-01.1 (external review process "applies to a health benefit plan that: (1) is delivered or issued in the State; or (2) covers individuals who reside or work in the State * * *"); CAL. HEALTH & SAFETY CODE § 1374.30(3) (external review requirements apply to "[e]very health care service plan contract that *is issued, amended, renewed, or delivered in this state* on or after January 1, 2000") (emphasis added); VA. CODE ANN. §§ 38.2-5901(A), 32.1-137.7 (independent review provisions apply to "a subscriber [or] policyholder * * * under a policy or contract *issued or issued for delivery in Virginia* by a managed care health insurance plan") (emphasis added); *with* AZ. STAT. § 20-2531 ("[T]his article applies to all utilization review decisions made by * * * health care insurers operating in this state"); KAN. STAT. ANN. § 40-22a04 (external review provisions apply to "utilization review services in this state or affecting residents of this state").

B. Illinois' Statute Is Not Saved From Preemption By The Insurance Saving Clause, Because Alternative Enforcement Mechanisms To Section 502(a) Are Not Laws That Regulate Insurance.

The conclusion that Section 4-10 constitutes an "alternative enforcement mechanism" to Section 502 forecloses respondent's claim that Section 4-10 is saved from preemption under ERISA's "saving" clause, 29 U.S.C. § 1144(b)(2)(A). In *Pilot Life*, this Court unanimously held not only that the remedies set forth in Section 502 were intended to be exclusive and thus preemptive of conflicting state laws under ordinary conflict preemption principles. It *also* held that the exclusivity of Section 502 informed interpretation of the "saving" clause. *See* 481 U.S. at 52. Indeed, the Court explained that Section 502(a)'s exclusive remedial scheme was the "most important[]" factor indicating that the state law was not the business of "insurance" that Congress intended to preserve for State regulation. *Pilot Life*, 481 U.S. at 52. *Pilot Life* thus stands for the proposition that the insurance saving clause will not save from preemption state laws that "supplement[] or supplant[]" the exclusive remedies that Congress made available under Section 502(a). *Id.* at 56.

1. Respondent contends, however, that Illinois' law should be invalidated under the saving clause only if "it would be impossible to comply with the state * * * regulation and ERISA" (Resp. Br. Opp. at 8).[6] Respondent places primary reliance on the statement in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), "declin[ing] to im-

[6] Respondent's argument is similar to the position taken by the United States in *Ward*. There, the Solicitor General suggested that ERISA's saving clause may save from preemption state insurance laws that conflict with the exclusive remedies provided by Section 502 of ERISA—even though his reasoning to the contrary had been adopted by a unanimous Court in *Pilot Life* (*see Pilot Life*, 481 U.S. at 52). *See* Br. of United States as *Amicus Curiae* in *Ward*, No. 97-1868 (filed November 1998), at 22-25.

pose any limitation on the saving clause beyond those Congress imposed in the clause itself." *Id.* at 746. Respondent reads that statement as requiring the Court to "[give] effect to the facially unrestricted scope of the insurance savings clause." *See* Resp. Br. in Opp. at 8. But as the Court expressly recognized in *Pilot Life*, "*Metropolitan Life* * * * did *not* involve a state law that conflicted with a substantive provision of ERISA." *Pilot Life*, 481 U.S. at 57 (emphasis added). Because Section 4-10 *does* conflict directly with the exclusivity of the remedies provided by Section 502(a), it is clearly preempted, by virtue of *Pilot Life*, even under respondent's own "conflict" test.

In any event, respondent is wrong to suggest that Section 4-10 is not preempted unless it makes "compliance with both state and federal law * * * impossible," *California v. ARC America Corp.*, 490 U.S. 93, 100 (1989). As this Court has recognized repeatedly since *Pilot Life* was decided, ERISA's preemptive reach extends to state laws—and even to state *insurance* laws—that stand as an obstacle to accomplishment of ERISA's objectives. *See John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) ("where [state insurance] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress, federal preemption occurs"); *see also Boggs*, 520 U.S. at 844 ("Conventional conflict pre-emption principles require pre-emption where compliance with both federal and state regulations is a physical impossibility, * * * or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.").

Moreover, whatever force the arguments advanced by respondent here (and the Solicitor General in *Ward*) may have, those arguments are plainly insufficient to justify reconsideration of *Pilot Life*'s holding that Section 502(a) pre-empts *all* state statutes that establish alternative enforcement mechanisms to Section 502(a), including those that would otherwise fall within the saving clause if Section 502(a) did not inform the scope of "insurance" that Congress intended to reserve for the States. This Court has recognized the high

burden that must be "borne by the party advocating the abandonment of an established precedent," especially where, as here, "the Court [may be] asked to overrule a point of statutory construction." *Patterson v. McLean Credit Union*, 491 U.S. 164, 172 (1989). That burden simply has not and cannot be met here.

None of the factors historically regarded as necessary to overturn a settled statutory interpretation is present here. There has been no "intervening development of the law" (*Patterson*, 491 U.S. at 173), casting doubt on that (or any) aspect of *Pilot Life*'s holding. To the contrary, the Court has repeatedly reaffirmed *Pilot Life* in a variety of contexts. *See Ingersoll-Rand*, 498 U.S. at 135; *Taylor*, 481 U.S. at 62-63. Nor has the rule of *Pilot Life* constituted an "obstacle" to important federal purposes or proved "inconsistent with the sense of justice or with the social welfare." *Patterson*, 491 U.S. at 174. Quite to the contrary, the number of employee welfare benefit plans has exploded in recent years, extending pension, disability, and health care coverage to more workers than ever before, largely, if not primarily, because of the certainty and predictability effected by this Court's holding in *Pilot Life*. *See* Paul Fronstin, *Employment-Based Health Benefits: Trends and Outlook*, Issue Brief No. 233, Employee Benefit Research Institute (May 2001) (noting sharp increase in number of employees covered by employer-sponsored health plans since 1994); U.S. DEP'T OF COMMERCE, BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES at 383, 535 (115th ed. 1995) (noting rapid growth of employee welfare benefit plans). Employers who adopted welfare benefit plans did so on the understanding that "the regulation of employee welfare benefit plans [w]as exclusively a federal concern." *Travelers*, 514 U.S. at 656; *see also Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). To unsettle those expectations by revisiting *Pilot Life* at this late date could scarcely fail "to deter some employers from offering health insurance at all." *Moran*, 230 F.3d at 973-74 (Posner, J., dissenting from denial of reh'g *en banc.*); *see also Fort Halifax*,

482 U.S. at 11 (narrowly construing ERISA's preemptive effect could cause "those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them").

Moreover, the interest in stability and predictability in the law strongly counsels against revisiting any aspect of *Pilot Life*. This Court has recognized that issues of ERISA preemption have "generated an avalanche of litigation in the lower courts." *De Buono v. NYSA-ILA Medical and Clinical Serv. Fund*, 520 U.S. 806, 808 n.1 (1997). The Court itself has decided 18 cases (the Court identified 16 in *De Buono* and since then has decided *Egelhoff* and *Ward*), and several of those were split and deeply fractured opinions. *See, e.g.*, *Boggs*, 520 U.S. at 833, 854; *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 841 (1988); *Fort Halifax*, 482 U.S. at 1, 22. This Court's unanimous opinions in *Pilot Life*, *Ingersoll-Rand*, and *Taylor* speak with an unmistakable clarity that over the long run has redounded to the benefit of plan participants and administrators alike. No compelling reason exists to revisit what has become a cornerstone—and perhaps the only clear, unambiguous rule—of this Court's ERISA jurisprudence. Section 4-10 constitutes an alternative enforcement mechanism and is accordingly preempted under *Pilot Life*, whether or not it otherwise might be said to regulate "insurance" under the alternative—and untested—world-view championed by respondent and the State in this case.

C. In Any Event, Illinois' Statute Does Not Regulate Insurance As A Common Sense Matter Or As Measured Under The Three McCarran-Ferguson Guideposts.

In any event, respondent's contention that Section 4-10 is a law regulating insurance within the meaning of ERISA's saving clause is meritless on its own terms. Section 4-10 is a regulation of HMOs, not insurance, and it expressly regulates HMOs when they are acting in purely administrative capacities. Thus, even assuming *arguendo* that in some circumstances a state law alternative remedy might escape *Pilot Life*'s preemptive reach, Section 4-10 is not saved from preemption here.

1. This Court's decisions in *Ward* and *Metropolitan Life* establish a framework for determining whether a law regulates insurance within the meaning of the saving clause. First, the court must determine "whether, from a 'common-sense view of the matter,' the contested prescription regulates insurance." *Ward*, 526 U.S. at 367 (quoting *Metropolitan Life*, 471 U.S. at 740). The court next must consider "three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act." *Ward*, 526 U.S. at 367. Those factors are "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and insured; and third, whether the practice is limited to entities within the insurance industry." *Ward*, 526 U.S. at 367; *Metropolitan Life*, 471 U.S. at 743.

The court of appeals erred in concluding that Section 4-10 regulates insurance from a "common-sense view of the matter." The court of appeals believed that Section 4-10 "is directed at the HMO industry *as insurers*." *Moran*, 230 F.3d at 969 (emphasis added). That conclusion, however, is belied by the definition of "HMO" in the Illinois Act, which includes any organization that performs services as part of any arrangement "which causes *any part* of the risk of health care delivery to be borne by the organization *or its providers*." 215 ILL. COMP. STAT. 125/1-2(9) (emphasis added). That definition covers not only HMOs that fully insure the risk of health care delivery, but also applies to HMOs that perform purely *administrative* services for self-funded plans, a fact that destroys any attempt by the State to rely on the saving clause under this Court's precedents. *See FMC Corp. v.*

Holliday, 498 U.S. 52, 61 (1990) (discussing "deemer" clause).[7]

For example, when HMOs contract to provide purely administrative services to self-funded plans, they frequently provide plan subscribers with access to networks of physicians credentialed by, and affiliated with, the HMO. HMOs contract with those physician networks in a multiplicity of forms, including "staff model," "group model," and "IPA model" arrangements.[8] Several of those arrangements involve payments to physicians on a "capitated" basis—*i.e.*, an agreement to pay physicians "[a] set amount of money * * *

[7] Texas' independent review statute also applies to HMOs that perform purely administrative services for *self-funded* plans. *See* TEX. INS. CODE ANN. art. 21.58, §§ 2(17)(B) and (C), 2(21)(B), 6 and 6A (independent review requirements apply to "*any* * * * person or entity which * * * *administers* * * * health benefits * * * pursuant to a policy, plan, or contract") (emphasis added).

[8] In a "staff model," the HMO "directly employs staff physicians and compensates them as salaried employees." Diana J. Bearden & Bryan J. Maedgen, *Emerging Theories Of Liability In The Managed Care Industry*, 47 Baylor L. Rev. 285, 292 (1995). The physicians are employees of the plan and make coverage decisions on behalf of the plan. The HMO at issue in *Pegram* was a "staff model" HMO. *See Pegram*, 530 U.S. at 215-17.

In a "group model," the HMO "contracts with a group of physicians (typically an incorporated group practice), rather than individual physicians, to devote all or much of its time to providing care to HMO members at the group's clinic and facilities for a fixed monthly fee per covered individual." Bearden & Maedgen, *supra*, 47 Baylor L. Rev. at 292-93. "The fixed per-member monthly fee is * * * referred to as a 'capitation rate.'" *Id.* at 293.

In an "IPA model," the HMO "contracts with an independent practice association, which is usually a partnership or corporation comprised of various independent practicing physicians. The association, in turn, contracts directly with each of its independent physicians with respect to terms and conditions of participation, including the method of payment." *Id.* The HMO "pays the IPA a specified capitation amount and the IPA, in turn, pays the participating physicians on a fee-for-service" or capitated basis. *Id.*

based on membership [numbers] rather than on services delivered." Peter R. Kongstvedt (ed.), THE MANAGED HEALTH CARE HANDBOOK at 988 (3d ed. 1996). Regardless of the quantity of services provided, therefore, the physicians' compensation is fixed, and thus the *providers—not* the HMO—bear "part" of "the risk of health care delivery" under the plain terms of the Illinois' statute. *See* Frank T. Herdman, *Doctors, Insurers, And The Antitrust Laws*, 37 Buffalo L. Rev. 789, 807 (1988-89) ("The primary benefit of a capitation system to an HMO is that the risk of providing health services is no longer borne by the HMO.") Thus, although the HMO's purely administrative arrangement with the self-funded plan has the effect of transferring "the risk of health care delivery to * * * providers" (215 ILL. COMP. STAT. 125/1-2(9)), the HMO itself does not assume any risk—the *sine qua non* of the "insurance" business, *see Group Life & Health Ins. Co. v. Royal Drug Co. Inc.*, 440 U.S. 205, 212 (1979) ("*Royal Drug*").[9] The court of appeals' conclusion that Section 4-10 is aimed "directly at HMOs *as insurers*" (*Moran*, 230 F.3d at 969) (emphasis added) therefore is manifestly erroneous under the plain terms of the State's statute.

The conclusion that Section 4-10 does not regulate insurance from a "common-sense view of the matter" finds further support in the history of the regulation of prepaid health plans. In *Metropolitan Life*, the Court upheld the state-

[9] *See generally* Herdman, *supra*, 37 Buffalo L. Rev. at 806-17 (explaining that risk is ordinarily borne by providers in products offered by HMOs to employers). This Court has noted the difference between traditional indemnity insurance plans and HMOs in this regard. *See Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 339 n.7 (1982) ("An alternative to the fee-for-service type of insurance plan is illustrated by the health maintenance organizations authorized under the Health Maintenance Organization Act of 1973 * * * * Under this form of prepaid health plan, the consumer pays a fixed periodic fee to a functionally integrated group of doctors in exchange for the group's agreement to provide any medical treatment that the subscriber might need. *The economic risk is thus borne by the doctors.*") (emphasis added).

mandated benefit law at issue in large part on the ground that it had been historically regarded as a traditional insurance law. 471 U.S. at 742-43. That is manifestly *not* true with respect to prepaid health arrangements, such as HMOs. In *Royal Drug*, the Court recognized that States that regulated prepaid health-service plans at the time the McCarran-Ferguson Act was enacted "either exempted them from the requirements of the state insurance code or provided that they shall not be construed as being engaged in the 'business of insurance' under state law." 440 U.S. at 226 (quotation and citation omitted).[10] That fact is significant, for as this Court recognized in *Metropolitan Life*, "[t]he saving clause and McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States." 471 U.S. at 744 n.21. The contemporary understanding that prepaid health plans "were not engaged in providing insurance" (*Royal Drug*, 440 U.S. at 227) is highly significant in ascertaining whether Congress intended to reserve regulation of all HMO activities to the States.[11]

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10 "Advance-payment" health plans such as Blue Cross & Blue Shield, which contracted with subscribers to arrange for health services and hospital care on a prepaid basis (and which compensated physicians at negotiated rates), were the non-profit precursors to the modern for-profit HMO. *See generally* Robert I. Cunningham *et al.*, THE BLUES: A HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM at 7-21, 210 (1997); Donald R. Levy (ed.), 2001 STATE BY STATE GUIDE TO MANAGED CARE (2001) at 1-3 ("A health maintenance organization is defined as a health plan that offers prepaid, comprehensive health coverage for both hospital and physician services.").

11 Indeed, only one year before it enacted ERISA, the 93d Congress enacted the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, codified at 42 U.S.C. §300e *et seq.*, to establish requirements for the administration and management of federally-qualified HMOs—a substantial legislative undertaking entirely inconsistent with the proposition that Congress understood the regulation of HMOs to be the type of traditional regulation of "insurance" that Congress intended to reserve to the States. As two commentators have observed: "The purpose of the 1973 Act was to *prevent* state laws from impeding the development of HMOs. In particular, Congress was concerned that local physicians' political

Finally, the conclusion that external review statutes such as Section 4-10 are not directed at the business of insurance is further cemented by examination of the circumstances in which those statutes have been enacted. As Judge Posner recognized, external review statutes constitute state legislative responses "to the recent torrent of criticisms of HMOs." *Moran*, 230 F.3d at 974 (Posner, J., dissenting from denial of reh'g *en banc*). Because HMOs are "the service providers under a great many ERISA medical-benefits plans" (*id.* at 973), including countless self-funded plans that could not be reached by the States under any conceivable interpretation of ERISA, *see FMC Corp.*, 498 U.S. at 63, the problem the States purported to address was by definition *not* "grounded in policy concerns specific to the insurance industry." *Ward*, 526 U.S. at 372.

All of these considerations point to the conclusion that the Illinois external review statute does not regulate insurance from a "common-sense view of the matter." *Ward*, 526 U.S. at 367. "A common sense view of the word 'regulates' [means] * * * that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically *directed* toward that industry." *Pilot Life*, 481

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clout with state regulators would prevent HMOs from developing as a more efficient means of delivering quality health care." Jeffrey W. Stempel & Nadia von Magdenko, *Doctors, HMOs, ERISA, And The Public Interest After* Pegram v. Herdrich, 36 Tort & Ins. L.J. 687, 734 n. 96 (2001) (emphasis added). The Senate Report to the bill that was ultimately enacted states unequivocally that "[i]n the committee's view HMOs * * * should not be required to submit to regulations as an insurer of health care services * * * * Such requirements would be unduly restrictive, onerous, and not within the spirit of this legislation * * * * " S. Rep. 93-129 *reprinted in* 1973 U.S.C.A.A.N. 3033, 3058 (1973). Indeed, the Report identifies "applicable state insurance laws and regulations" as one of the "[p]rincipal state legal barriers * * * to the development of HMOs." *See id.*; *see also Pegram*, 530 U.S. at 233 ("The fact is that for over 27 years the Congress of the United States has promoted the formation of HMO practices.").

U.S. at 50 (emphasis added). Section 4-10 does not remotely satisfy that standard.[12]

2. At the petition stage, respondent contended that Section 4-10 was properly construed as a law regulating insurance under a "common sense review of the issue" because nothing would prevent an ERISA plan from voluntarily adopting an identical external review provision itself. *See* Br. in Opp. at 7. According to respondent, "if a plan can voluntarily purchase insurance with an independent review provision, then a state, via the insurance regulation exception to ERISA preemption, can require it." *Id.* That theory can scarcely be used to uphold state *external* review statutes, whose distinguishing characteristic is that strangers to the plan—who are not fiduciaries and who frequently are shielded from any legal liability for their actions—make judgments about how plan assets must be spent that are *binding* on plan administrators.

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[12] The court of appeals concluded that Section 4-10 regulates insurance as a common-sense matter by adverting to a precedent holding that HMOs "'are insurance vehicles under Illinois law.'" *Moran*, 230 F.3d at 969 (quoting *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994)). This Court has on occasion expressed reluctance to "disturb an appeals court's judgment * * * heavily dependent on analysis of state law." *Ward*, 526 U.S. at 368 (citing *Runyon v. McCrary*, 427 U.S. 160, 181-82 (1976)). That principle, however, applies only where the "District Court and Court of Appeals have concurred" on the state law's meaning (*Runyon*, 427 U.S. at 181; *see also Bishop v. Wood*, 426 U.S. 341, 346 (1976) (same)), which is not the case here. In any event, whether Section 4-10 is a law that "regulates insurance" under ERISA's saving clause is plainly governed by federal law. *See* 29 U.S.C. § 1144(b)(2)(A). The subsidiary judgments necessary to interpret that provision *also* present federal, not state, questions. *See SEC v. Variable Annuity Life Ins. Co. of Am.*, 359 U.S. 65, 69 (1959) ("the meaning of 'insurance' under * * * Federal Acts is a federal question"). Indeed, it is far from clear why a court of appeals' judgment on a matter of "common sense" is entitled to deference, particularly where, as here, that judgment does not depend on an *interpretation* of a state's law, but on an assessment of its *effect*.

Contrary to respondent's suggestion, there are substantial limits on the authority of a plan administrator to delegate final claims-processing authority to an outside party not bound by fiduciary duties. Any such delegation would likely violate the express terms of Section 503, which requires every employee benefit plan to "afford a reasonable opportunity to any participant whose claim for benefits has been denied a full and fair review *by the appropriate named fiduciary* of the decision denying the claim." 29 U.S.C. § 1133(2) (emphasis added). In addition, the delegation of claims processing to a party not bound by fiduciary duties is *itself* likely to constitute a breach of fiduciary duty by the plan administrator. Claims processing is a fiduciary function. *See* Susan P. Serota, ERISA FIDUCIARY LAW 152-53 (1995) (collecting cases). A plan administrator necessarily abdicates its statutorily-mandated fiduciary duty to review claims fully and fairly when it delegates final claims-processing authority to a nonfiduciary. Benefit determinations conducted pursuant to such a delegation are in all likelihood invalid, because "no discretion w[ill have been] exercised by the body given that authority under the terms of the Plan." *Nelson v. EG&G Energy Meas. Group, Inc.*, 37 F.3d 1384, 1388 (9th Cir. 1994).[13]

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[13] Although Moran also argued in the court of appeals that external review statutes might be upheld as a form of permissible "arbitration," *see* Br. of Plaintiff-Appellant Moran at 21-22, her argument ignores that Congress, by statute, has adopted a strong policy in favor of *voluntary* arbitration, and also specified the consequences of such an agreement, the available methods for enforcement, and the appropriate standards for judicial review. Under Congress' scheme, arbitration conducted pursuant to the Federal Arbitration Act, 9 U.S.C § 1 *et seq.*, is not an *alternative* enforcement mechanism to Section 502, but a federally-sanctioned *substitute* for it. *See Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 628 (1985). Given that "[w]ithout the FAA's strong policy in favor of arbitration to tip the scales, an ERISA plaintiff might * * * show that an ERISA-governed plan's arbitration clause is unenforceable because it conflicts with statutory provisions or regulations governing the judicial review of benefits determinations under ERISA" (*Chappel v. Laboratory Corp. of Am.*, 232 F.3d 719, 725 n.4 (9th Cir. 2000)), it fol-

Indeed, even if delegation of claims-processing authority to a non-fiduciary *were* proper in some circumstances, the plan administrator would be required to monitor and supervise the delegatee's conduct, *see* 29 U.S.C. § 1105(c)(2)(A)(iii)—a duty that would be impossible to execute given that plan administrators have no discretion to review or set aside an external reviewer's benefits determination. Thus, respondent's claim that Section 4-10 is an insurance law because plan administrators can adopt external review on their own is premised on an erroneous assumption: ERISA's fiduciary requirements would prevent the plan administrator from abdicating his authority to a third party, not bound by fiduciary duties, whose decisions about how plan assets will be spent are binding on the administrator.[14]

3. Nor does Section 4-10 satisfy any of the three McCarran-Ferguson Act factors. Section 4-10 does not meet the first McCarran-Ferguson factor because external review does not transfer or spread a policyholder's risk. In *Union Labor*

[Footnote continued from previous page]

lows *a fortiori* that *state* independent review statutes, which lack *any* federal mandate, and which are imposed by operation of law on unwilling parties, cannot evade invalidation as alternative enforcement mechanisms to Section 502.

14 It is no response to suggest that this Court might solve the problem with respondent's theory by decreeing that the external reviewers will become subject to fiduciary duties by operation of law. Virtually all state independent review laws provide essentially blanket immunity to independent reviewers for claims arising out of their independent review services. *See, e.g.*, 215 IL COMP. STAT. 134/45(f)(6); 28 N.Y. INS. LAW § 4914(c); TEXAS INS. CODE Art. 21.58C § 2(g); VA. CODE ANN. § 38.2-5902(C). If this Court were to mandate that all independent reviewers be treated as plan fiduciaries, it also would be required to invalidate the provisions that immunize those presumed "fiduciaries" from civil liability, at least to the extent necessary to subject them to suit under ERISA's remedial scheme. It hardly needs stating that this Court should not invalidate one state law to save another, especially where neither law might have passed if the state legislature had labored under a correct apprehension of federal requirements.

Life Ins. Co. v. Pireno, 458 U.S. 119 (1982), this Court held that a peer review committee's examination of whether medical care provided to an insured is reasonably charged and medically necessary does not "spread[] and underwrit[e] * * * a policyholder's risk." *Id.* at 130. As this Court recognized, risk is allocated when the insurance contract is executed, not when particular claims are adjusted. *Id.* Like the external review mechanism at issue in *Pireno*, the independent review authorized by Section 4-10 is "logically and temporally unconnected to the transfer of risk accomplished by" its subscriber contracts, even if those contracts otherwise could be viewed as "insurance." *Id.* The first McCarran-Ferguson factor therefore is not satisfied.[15]

Nor is Section 4-10 an "integral part of the policy relationship between insurer and insured" (*Pireno*, 458 U.S. at 131)—the second factor. External claims review procedures do not "so closely affect[] the reliability, interpretation, and enforcement of the insurance contract * * * as to fall within the [business of insurance]," because external review "is a separate arrangement * * * [with] third parties not engaged in the business of insurance," even if, as was true in *Pireno*, the insurer uses the peer review system "as an aid in its [claims] decisionmaking." *Id.* at 130-32. As this Court recognized in *Department of Treasury v. Fabe*, 508 U.S. 491, 503 (1993), such mechanisms have "nothing to do with whether the insurance contract [is] performed; [they] deal only with calculating what f[alls] within the scope of the contract's coverage"—*i.e.*, precisely what federal courts are

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15 The court of appeals did not address whether Section 4-10 spreads or transfers a subscriber's risk, even though that factor constitutes the "one 'indispensable characteristic of insurance.'" *Pireno*, 458 U.S. at 130 (quoting *Royal Drug*, 440 U.S. at 212); *see also Variable Annuity Life Ins. Co.*, 359 U.S. at 71 ("the concept of 'insurance' involves some investment risk-taking on the part of the company"). The Fifth Circuit in *Montemayor* recognized that Texas' independent review provisions "probably do not * * * reallocat[e] the risk between the insured and insurer." 215 F.3d at 538.

called upon to decide under ERISA § 502(a). The second McCarran-Ferguson factor therefore is not satisfied.

Finally, Section 4-10 is *not* aimed directly at the insurance industry. The statute applies to HMOs, including those that perform purely administrative functions for self-funded plans. Because on its face Section 4-10 is not "limited to entities within the insurance industry" and is not "a law governing the insurance relationship distinctively" (*Ward*, 526 U.S. at 375), the third McCarran-Ferguson factor is not satisfied.

D. Summary Judgment For Respondent Was Improper.

Thus, the court of appeals erred in granting summary judgment to Moran. Section 4-10 constitutes an alternative enforcement mechanism to Section 502 and in any event does not "regulate insurance" from a common-sense view of the matter or satisfy any of the three McCarran-Ferguson factors. Accordingly, it is preempted by Section 502(a) and 514(a) and is not saved from preemption under the saving clause. Rush therefore was not obliged to comply with the independent reviewer's determination that Dr. Terzis' surgery was "medically necessary," and its rejection of Moran's benefits claim was not otherwise an abuse of discretion. *See Firestone Tire & Rubber Co.*, 489 U.S. at 107.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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